



Client No. 2036		Client Name OAM		Location OSWEGO ST. UTICA, N.Y.		Date 11/17/86													
Facility Equipment	Detex Clock No. <input checked="" type="checkbox"/>	Weapon No. <input checked="" type="checkbox"/>	Holster <input checked="" type="checkbox"/>	Nightstick <input checked="" type="checkbox"/>	Raiscoat <input checked="" type="checkbox"/>	Flashlight <input checked="" type="checkbox"/>	Other												
Officers: Fully explain all items marked "Yes" with time and all detail. For additional space use reverse side and attach incident reports.				Officer—Day Shift (Name) CHUFF		Officer—Swing Shift (Name)													
				Shift		Shift													
				Began 11 AM PM Ended 12 MID. AM PM		Began AM-PM ended AM-PM													
Observations or actions taken				Yes No Explanation		Yes No Explanation													
Rounds or stations missed				<input checked="" type="checkbox"/> SEE REMARKS															
Unlocked doors, gates or windows				<input checked="" type="checkbox"/>															
Unlocked vaults or safes				<input checked="" type="checkbox"/>															
Fire-smoke-or hazards				<input checked="" type="checkbox"/>															
1. Extinguishers missing or defective				<input checked="" type="checkbox"/>															
2. Sprinkler system defective				<input checked="" type="checkbox"/>															
3. Fire doors or exits blocked				<input checked="" type="checkbox"/>															
4. Rubbish accumulation				<input checked="" type="checkbox"/>															
5. Motors running				<input checked="" type="checkbox"/>															
6. Lights left burning				<input checked="" type="checkbox"/> AS NEEDED															
Injury hazards				<input checked="" type="checkbox"/>															
Visitors				<input checked="" type="checkbox"/>															
Trespassing				<input checked="" type="checkbox"/>															
Violation of company rules				<input checked="" type="checkbox"/>															
Remarks MADE VISUAL CHECK OF PERIMETER OF BLDG. EVERY HR. (PC)																			
IMPORTANT: If you were ill or injured please explain on the reverse side of this form and call your supervisor before leaving this post.																			
1. Were you injured during this tour?		Day Shift 1. Yes No <input checked="" type="checkbox"/>		2. Yes No <input checked="" type="checkbox"/>		3. Yes No <input checked="" type="checkbox"/>		Swing Shift 1. Yes No <input checked="" type="checkbox"/>		2. Yes No <input checked="" type="checkbox"/>		3. Yes No <input checked="" type="checkbox"/>		Grave Shift 1. Yes No <input checked="" type="checkbox"/>		2. Yes No <input checked="" type="checkbox"/>		3. Yes No <input checked="" type="checkbox"/>	
2. Did you suffer any illness?		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>	
3. Have you reported all accidents coming to your attention?		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>		Yes No <input checked="" type="checkbox"/>	
Signatures		1. Phil Chuff		2.		3.		Swing Shift 1.		2.		3.		Grave Shift 1.		2.		3.	
Signatures		2.		3.				2.		3.				2.		3.			
Signatures		3.						3.						3.					

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